Provider Profile Form
North Dakota Department of Health
Prevention Partnership Program

Provider I.D. Number

All Prevention Partnership providers must complete this form. This document provides shipping information and helps the state determine the amount of vaccine supplied through the Vaccines for Children Program. One provider for the entire practice may complete this form.

Physician/Provider Name:_____
Last Name First Name MI

Facility/Clinic Name:_____

Address: _____
Street City State Zip Code

Contact Name(s):_____
Title

Telephone:_____ **Fax:**_____ **E-Mail:**_____

Are you currently using the North Dakota Immunization Information System? ☐ **YES** ☐ **NO**

Type of Facility (please check only on box):

- ❑ Public Health Department
- ❑ Rural Health Clinic (RHC)
- ❑ Federally Qualified Health Center (FQHC)
- ❑ Private Practice (Individual or Group)
- ❑ Public Hospital
- ❑ Private Hospital
- ❑ Other Public Facility
- ❑ Other Private Facility

Vaccine Delivery Address (if different from above):

_____
Street City State Zip Code

Provider Estimates:

For the 12 mo. Period beginning **01/01/2006** Estimate the number of children who will receive vaccinations at your health facility by age group. Only count a child once in each 12 month period no matter the number of visits. Please document if your facility sees out of state children. Please provide a separate estimate for VFC-eligible out of state children.

< 1 Year Old	1-6 Years	7-18 Years	Total

Type of data used to determine profile:

A. Benchmarking_____
B. Medicaid Claims Data_____
C. Dose Administered_____
D. Provider Encounter Data_____
E. Registry_____
F. Other_____

For State use only:

Immunization Program Representative:	Date Certified for Prevention Partnership: